

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4712	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/23/2011
NAME OF PROVIDER OR SUPPLIER SERENE MANOR MEDICAL CTR.			STREET ADDRESS, CITY, STATE, ZIP CODE 970 WRAY ST KNOXVILLE, TN 37917		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	<p>Initial Comments</p> <p>During a complaint investigation at Serene Manor on June 2,3 2011, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.</p> <p>C/O: #28247</p>	N 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

6X0B11

If continuation sheet 1 of 1